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What's the Deal with Blood Cancers? Navigating a New Frontier in Palliative Cancer Care (TH313)



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Objectives

- Recognize evidence about areas of unmet palliative care needs in the blood cancer population.
- Understand oncologists' unique perspectives about blood cancers, and identify barriers to palliative care integration.
- Develop strategies to align the palliative care and oncology teams to improve integration and promote early palliative care in the blood cancer setting.

Blood cancers account for over 55,000 annual U.S. cancer deaths, a number higher than the 40,000 expected from breast cancer, yet they receive comparatively little attention in discussions about palliative cancer care. While concurrent palliative care is heralded as a standard for patients with advanced solid tumors, those with blood cancers are less likely to use palliative care services, and are more likely to receive aggressive care at end of life, chemotherapy in their last 14 days, and to die in the hospital. These shortcomings highlight unmet needs that warrant further attention and education in the palliative care community. When we talk with blood cancer specialists, they often complain that palliative care clinicians do not understand blood cancers, and that this reduces their willingness to call a consult. Our session proposal will help remedy this knowledge gap.

Contrary to popular belief, these diseases are seen and treated in academic centers and community-based settings alike, often in outpatient settings. Yet blood cancers pose several unique challenges for palliative care clinicians, including highly-variable prognoses, greater responsiveness to treatment, rapidly-evolving treatments, and often a chance of cure. Our presentation highlights the unique challenges posed by this population, with attention to strategies that have paid dividends in our own practices caring for them. A multi-institutional, multi-disciplinary team of presenters with training in oncology and palliative medicine will utilize a case-based approach to discuss these issues,

including perspectives from a clinician who built a palliative care program within a stem cell transplant unit, two who have done trials of early palliative care in hematologic malignancies, and one who is seeing these patients regularly in palliative care practice and as part of clinical trials. We have presented on this topic at national oncology venues, and wish to bring this important perspective to the palliative care community.

Interdisciplinary Team Training at the Art Museum: Breaking Down Hierarchy and Building Resilience (TH314)



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Objectives

- Describe the evidence supporting the use of museum-based education (MBE) to develop core clinician competencies of perception, empathy, reflective practice, and resilience.
- Recognize how MBE can improve interprofessional practice by decreasing perceived hierarchy and promoting team building.
- Experience an MBE session.

Burnout among palliative care practitioners can lead to poor performance and attrition. Museum-based education (MBE) is an innovative strategy that aims to reduce burnout by enhancing perception and empathy, flattening perceived hierarchy, and strengthening interprofessional teams. The goal of this session is to provide palliative care educators with evidence and approaches to use art as a strategy to promote team building and enhance clinically relevant observation and reflective competencies.

MBE employs specific pedagogical strategies to train participants to intentionally, thoughtfully, and reflectively perceive patients and their unique situations. It is also a strategy to lessen a sense of hierarchy among teams by connecting participants to others' personal perceptions and histories, irrespective of professional role. MBE participants have improved perception, comfort with ambiguity, and empathy, making this an important tool for palliative care teams and training programs as they seek to foster effective interprofessional teams and professional resilience.

This session will highlight current evidence supporting MBE in healthcare, as well as ongoing work by palliative care programs with trainees and interprofessional teams. Finally, we will demonstrate examples of art-based teaching strategies with audience participation such that participants may begin to design MBE programs tailored to their home institution.

Partnerships in Dialysis and Palliative Care & Hospice: Innovative Models for End-of-Life Care for End-Stage Renal Disease Patients' (TH315)



Keith Lagnese, MD FACP HMDC, University of Pittsburgh School of Medicine, Pittsburgh, PA. Jane Schell, MD, University of Pittsburgh, Pittsburgh, PA.

Objectives

- Describe the end of life outcomes for end stage renal disease (ESRD) patients and the need for innovative models of care for this population.
- Dialysis organization perspective: Describe an Innovative Model for concurrent hospice and dialysis patients.
- Hospice organization perspective: Expanding Access for ESRD patient's within Current Medicare Hospice Benefit (MHB)

As multiple different studies and surveys continue to illustrate, palliative and hospice medicine has failed to have an appropriate impact on the quality of life for the end-stage renal disease (ESRD) population. People with Chronic Kidney Disease (CKD) remain less likely to die at home, spend more time in the hospital and at higher costs in the last 3 months of life. (Kerr M et al, NDT, 2016).

The tide does to be slowly changing 'upstream' as aggressive dialysis centered care intersects further with palliative patient-centered approaches for this fragile patient population. The evolution of movements such as Comprehensive Conservative Care (CCC) focus on holistic patient-centered care for patients with stage V CKD (Davison et al Kidney Int 2015). Another example would be similar work being done by The Coalition for Supportive Care of Kidney Patients. Nearly all CKD patients want to discuss their prognosis, treatment options and ultimately die comfortably at home. (Clin J Am Soc Nephrol 5: 2010) Fortunately this has not gone unnoticed by the ultimate original payer, Medicare, and hence in 2013, CMMI's demonstration project for ESRD holds renewed hope with creation of new coordinated programs with new acronyms: CEC (comprehensive ESRD Care) and ESCO (ESRD seamless care organizations). We will not only look at national U.S. ESCO outcomes data, but will share a detailed information about Dialysis Clinic Inc (DCI) experiences with this truly innovative model. As the largest non-profit

dialysis provider in the U.S. we will go beyond the data and share first hand details of care coordination strategies and how the field of nephrology has begun to reset its paradigm for treating CKD. The role of palliative and hospice care in the ESCO model also be discussed.

Unfortunately, further downstream in the trajectory of life for ESRD patients, the dialysis churn for the Medicare population continues to limit access to hospice. In a very recent large cross-sectional study of 770,000 Medicare beneficiaries, only 20% of these patients enrolled in hospice and of this subset, nearly half only enrolled for 3 days or less. Although dying at home was more likely in the hospice patients, they did not fare any better in regards to hospitalization, ICU admits and overall healthcare costs in the last week of life. (Wachterman et al; JAMA Int Med April 30, 2018).

In order to increase hospice access for dialysis dependent patients, we will explore the history of 'Open Access' models as well as share outcomes on 'Expanded Access' program within a large not for profit hospice in PA. (UPMC Family Hospice). We will show how close coordination with Palliative nephrologists can result in significant increase in hospice length of stay as well as patient satisfaction and decreased hospitalization. Lastly, we will share our thoughts on how the Medicare hospice benefit 'Carve-In' model will likely increase hospice Los for dialysis patients through improved care coordination.

No Patient Left Behind: Integrating Addiction Treatment with Buprenorphine into Your Outpatient Palliative Care Practice (TH316)



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Objectives

- Describe the principles of buprenorphine (Suboxone) prescribing for opioid use disorder.
- Identify different strategies that outpatient palliative care practices can use to incorporate buprenorphine treatment of addiction into their setting.
- Discuss how to overcome barriers to implementing buprenorphine prescribing within their palliative care practices.

Patients with serious illness are not exempt from opioid use disorders raging through our communities. Outpatient palliative care clinicians are increasingly